Office of Licensing Program/Site Initial License Application

PLEASE USE A SEPARATE APPLICATION FOR EACH SITE REQUESTED

❖PROGRAM SITE INFORMATION

Site Name – Name to Appear on License

Site Street Address of License

Site City, State, Zip

Site Telephone Number

Site Contact Name

Site Email Address

❖PARENT ADMINISTRATIVE PROGRAM

(for programs with more than one licensed site)

Parent Program Name

Administrative Mailing Address (if different from site)

City, State, Zip

Administrative Telephone Number

Administrative Contact Name

Administrative Email Address

Program/Site Website(s): _____

Is this program owned or governed by any other entity (other than listed as parent)? ☐No ☐ Yes
If yes, please list Organization Name: _____

Contact Person:_____ Phone:_____ Email:_____

Is this application being submitted in regard to (Please check all that apply):

☐ A change in ownership with a substantial change of the program as outlined in R501-1-6-6? Please explain:_____

☐Adding a new license category to a currently licensed site (R501-1-6-4)?

☐Adding a new site to a currently licensed program? ***note**: for relocation of already licensed sites, please use the Renewal Application*

❖ CLIENTS TO BE SERVED AT THIS SITE

Total Capacity # Requested: _____

☐Youth (under age 18) ☐Adults ☐Male ☐ Female

❖ LICENSE CATEGORY AND FEES (follow links to see applicable rules and definitions).

☐	Adult Day Care	$900	☐ Outpatient Treatment	$900
☐	Child Placing Foster	$250	☐ Child Placing Adoption	$900
☐	Day Treatment	$900	☐ Social Detoxification	$900
☐	Intermediate Secure Care	$900	☐ Outdoor Youth	$1,408
☐	Therapeutic School	$900	☐ Residential Support	$900
☐	Residential Treatment	$900	☐ Recovery Residence	$1,295

In addition to categorical rules, all licensees are required to also adhere to:
General Provisions (R-501-1), Background Screening rules (R-501-14), and Core rules (R-501-2) *the only CORE exceptions are: Adult Daycare and Outpatient Treatment* All Licensing rules may be accessed via the links on this page or: http://www.rules.utah.gov/publicat/code/r501/r501.htm

❖ SPECIALIZED SERVICES REQUESTED

☐None ☐Domestic Violence Treatment ☐Domestic Violence Shelter
☐Substance Use Disorder ☐Temporary Youth Homeless Shelter
☐Medication-Assisted Substance Use Disorder Treatment
☐ Mental Health ☐Other:_____

❖ PROGRAM AFFILIATIONS

If this site is accredited (or applying for accreditation) by a nationally recognized accreditation organization, please list the following:
Organization Name:_____
Contact name:_____Contact phone:_____Contact email:_____

If this site is certified (or applying for certification) by the Division of Substance Abuse and Mental Health, please check all that apply: ☐None☐DUI Education☐Juvenile Reform Initiative Services (JRI)

If this site is under contract with (or applying for a contract with) a Division or Office of the Department of Human Services, please check all that apply: ☐None ☐Division of Child and Family

Services ☐Division of Juvenile Justice Services ☐Division of Services for People with Disabilities ☐DSPD Life Safety Inspection (**add $600.00 to fee amount**) ☐Other:_____

❖ PROGRAM GOVERNANCE

Please list all program owners and directors (as defined in R501-1) and all individuals ultimately responsible for operations and business decisions of this site. ***note:** personal information is private and used only for OL to contact responsible parties in the event of a closure or interruption in services*

Name:_____ Role/Title:_____ Home Phone:_____
Home Address:_____
Personal Email:_____

Name:_____ Role/Title:_____ Home Phone :_____
Home Address:_____
Personal Email:_____

Name:_____ Role/Title:_____ Home Phone :_____
Home Address:_____
Personal Email:_____

Name:_____ Role/Title:_____ Home Phone :_____
Home Address:_____
Personal Email_____

☐If there are more individuals to be listed, please check this box and provide an additional page as an attachment.

Please list the days and hours of site operation: _____

Please list the name of the director to be immediately available at all times that the program is in operation:_____. *When not available, a designee must be assigned and available*

❖ REQUIRED DISCLOSURES

While potential conflicts of interest are not inherently a barrier to licensure, they need to be appropriately managed and declared with transparency to the Office and potential clients. Please list any potential conflicts of interest that may exist in the relationships and services provided or referred to by individuals associated with this site. Please attach a plan to mitigate these conflicts.

_____
_____
_____
_____

Has this program (or any associated individuals) applied for and been **denied** DHS licensure within the 3 months prior to the date of this application? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Have any of the individuals associated with this program been an associate of a program that has had its license **revoked** within the past 5 years? ☐ Yes ☐ No

If yes, please explain with names, dates and circumstances:

_____

_____

_____

☐ If additional pages are necessary for this section, please check this box and provide as attachments.

Does this program store, administer, distribute or dispense controlled substances? ☐ Yes ☐ No

If yes, please list the following for all prescribing licensed practitioners:

Name_____ DOPL #_____ DEA #_____

Name_____ DOPL #_____ DEA #_____

☐ If there are more individuals to be listed, please check this box and provide as attachment.

DEA Registration Number for this site:_____

❖ REQUIRED DOCUMENTATION

The following checklist of items will be required as part of the initial licensure process. To expedite the processing of your application and assignment of a licensor, please submit as many of these required documents at the time of application as possible. If not accompanying the application, these supporting documents may be emailed **ONLY AFTER** the application and fees have been submitted via mail or in-person.

☐ Please provide copies of permits or clearances required by the local government (or documentation showing exemption) to include: fire clearance, health department clearance/food handling permits and business license.

☐ Please provide proof of current insurance policies to include: general liability, fire, vehicle (if transporting clients) and professional liability insurance.

☐ Please provide a copy of an outline of the organizational structure of the agency (lines of authority, position titles, job descriptions etc.).

☐ Please provide copies of current DHS contracts, certifications and accreditations held at this site.

☐ Please submit any attachments needed to expand the information listed in the “Governance” and “Disclosures” sections of this application.

☐ Please provide a copy of the required policies and procedures manual as required in R501-2 (or 501-21 for Outpatient and 501-13 for Adult Daycare) to also include the following in the event of a program closure or interruption in services:
-policy for the transition of clients
-policy regarding retention and availability of records following closure

☐ For Day Treatment, Residential Treatment, Recovery Residence, Adult Daycare, Therapeutic Schools and Intermediate Secure Care categories: Please submit a floor plan outlining designated space and measurements for capacity determination.
Note: licensed capacity must be congruent with fire inspection and business license determinations to include all staff and visitors when there is a maximum capacity noted. Client capacity will be the sole capacity determinant when the business license/fire clearance clearly designate as such.

☐ For Residential Treatment category: Please submit the notice of intent and proof of service submitted to the city where the licensed facility will operate (per 62A-2-108.2-4 and 5).

☐ For Residential Treatment programs serving education entitled children, please submit accreditation or educational service and funding plans approved by the school board or superintendent per 62A-2-108.1.

☐ Please complete and place comments in the applicable OL checklists (CORE/Categorical) to help you prepare your physical facility and expedite licensure. It is strongly recommended that this be done repeatedly throughout the licensing year to assist in maintaining ongoing compliance and providing the highest quality of care and services to the clients served.

❖ REQUIRED BACKGROUND SCREENING APPLICATIONS

☐ Please submit Background Screening applications and fees for all staff (in compliance with R501-14.)
PLEASE NOTE THAT APPLICANTS MAY NOT PROVIDE ANY DIRECT ACCESS TO CLIENTS OR CLIENT IDENTIFYING INFORMATION UNTIL ALL INDIVIDUALS WITH SUCH ACCESS HAVE CLEARANCES APPROVED BY THE OFFICE OF LICENSING

- For all staff: complete the application on this link.
- To request a formal **Program Exemption Application** from background clearances (substance abuse programs serving adults only) use this link.

❖ INFORMATION REGARDING FEES

Required fees: **Background Screening Application Fees** (outlined on the screening application) **and License Category Fees** (outlined on page 2 of this application).

- **Only cashier's checks, money orders or company checks** made payable to DHS Office of Licensing will be accepted. Please **no cash or personal checks**.
- Please note that no license will be issued until all fees have been cleared.

- Each categorical license at this site requires its own fee. Please note that a fee shall not be transferred, prorated, reduced, waived, or refunded and all costs incurred by applicants in preparation for licensure are the sole responsibility of the applicant (R501-1-7-5).

❖ DECLARATIONS

I declare the following:

- **I am an authorized representative of this program.**
- **I have reviewed and understand the Licensing rules applicable to this site.**
- **The information provided within this application is thorough, accurate and true.**
- **I have thoroughly identified all individuals responsible for this site.**
- **I understand that this application may be denied (or a penalty assessed, once licensed) for providing misleading or false information to the Office of Licensing, program clients, prospective clients or the public.**

Name of individual completing this application: _____
Title: _____ Date_____

(Electronically filling in or signing and submitting this application constitutes acknowledgment of thorough and truthful application information disclosure).

SUBMIT

Please submit this form and accompanying documentation and fees

to: **DHS Office of Licensing Intake Licensor**
195 North 1950, West Salt Lake City, UT 84116

Main Office: **801-538-4242** Intake Licensor **385-321-5585** Fax: **801-538-4553**
Intake Licensor email address: licenseapps@utah.gov
note**: **email is only for inquiries and supporting documentation, NOT for submission of application
no supporting documents will be accepted until an application and fee have been submitted together via mail or hand-delivery

❖ FOR OFFICE USE ONLY ❖

Initials of OL worker processing the application and fees: _____ Fees are: ☐Accepted ☐Returned
If returned: Reason_____ Date_____
Action requested_____

_____	_____	_____	_____
Date fee accepted	Amount submitted	Check number	Check date

☐Application Accepted ☐ Application Denied via NAA. Reason: _____